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ABSTRACT

This report outlines five strategic commitments that the Association of American Medical Colleges (AAMC) has adopted to help academic medicine's leaders uphold their institutional missions while adapting to the changes restructuring American medicine. It discusses the achievements and challenges of academic medicine in the changing health care environment, including pressure to contain costs, consolidation of payers and providers, empowerment of non-physician health care providers, shifts from a specialist-centered to a generalist-centered health care system, and retrenchment of public investment in clinical training and research. It then explains the AAMC's five strategic commitments, which focus on: (1) championing medical education integrated with research and patient care; (2) advocating academic medicine's missions of education, research, and patient care; (3) acting as an integrating force for academic medicine; (4) acting as an agent for change within academic medicine; and (5) providing services and information to the leaders and institutions of academic medicine. Three high priority concerns identified by AAMC members include the need for reliable information, strengthened advocacy, and leadership. The organization and governance of the AAMC are outlined. (MDM)

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ED 392 321

TAKING CHARGE OF THE FUTURE

The Strategic Plan

for the Association of American Medical Colleges

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Executive Summary

Following a 30-year period of phenomenal growth, academic medicine faces a new era of constrained resources and heightened accountability for the nation's health care. Each of its missions—education, research, and patient care—faces wrenching changes during this period of transformation. Among the key forces driving these changes are increasing pressure to contain health care costs, consolidation of health care payers and providers, the empowerment of non-physician health care providers, movement from a specialist- to a generalist-oriented health care system, and reductions in public investments in clinical training and medical research.

For medical schools and teaching hospitals to succeed or even survive in this milieu will require substantial changes to their programs, activities, and structures over the coming years—changes that must not endanger the underlying values and beliefs that guide academic medicine's missions. The AAMC developed this strategic plan to support its constituents in this change process, and to provide a forum for academic medicine to re-examine its traditions, identify and affirm its core values, and align itself with the future.

The AAMC has adopted five strategic commitments to help academic medicine's leaders uphold their institutional missions while adapting to the tumultuous changes that are restructuring American medicine. The Association will be the *champion of medical education*, the *advocate for academic medicine's missions*, an *integrating force for academic medicine*, an *agent for change* within academic medicine, and a *provider of services and information* to academic medicine.

Priority Concerns

The strategic plan identifies three areas of immediate concern for academic medicine and proposes new initiatives to address these.

Information: The need for accurate, immediate information has never been greater for members of the academic medicine community. In response, the Association will launch several new initiatives designed to provide the most current and complete information to its constituents. These initiatives include an expanded roster of educational seminars; the implementation of innovative information technologies; and new studies examining questions of faculty size and composition, medical education curricula, and medical school objectives, among other issues.

In addition, the Association has created the Center for the Assessment and Management of Change in Academic Medicine. This center will explore trends in medical center and faculty organization and governance, in education and research, and in the integration of clinical services. It also will develop information on innovations and models that might be replicated widely to help institutions of academic medicine adapt to resource constraints and other environmental stresses while fulfilling their core missions.

Advocacy: More than ever, academic medicine must engender understanding and support among policymakers and the public at large. To this end, the Association is intensifying its advocacy efforts with the federal government's legislative and executive branches by organizing more constituents' visits to key congressional members, staffers, and federal agencies; hiring experienced consultants to help shape strategies and tactics; and augmenting its in-house governmental relations staff.

The Association also will seek new strategic alliances with selected professional organizations and private sector stakeholders, and will increase the involvement of key leaders from all segments of the

academic medicine community in AAMC policy formulation. In addition, expanded communications efforts utilizing print and electronic media will foster broader understanding among key audiences of the issues affecting academic medicine.

Leadership on Workforce Issues: The AAMC has worked from its inception to help academic medicine produce an appropriate workforce to meet the country's changing needs and expectations. The Association has guided several successful initiatives to increase the number of underrepresented minorities and women in medicine, and to help achieve a proper balance between the number of generalist and subspecialist physicians.

In addition to expanding the scope and effectiveness of its ongoing activities in the workforce arena, the Association will

- convene a national physician workforce study group to strengthen the analytic base for projecting future needs in the various medical specialties
- advocate a reduction in the number of international medical graduates who train and eventually practice in the United States
- assist graduate medical education program directors in identifying ways to reduce reliance on residents as providers of critical patient care services
- strengthen career counseling services for U.S. medical students

The Association also will lead efforts to study pre- and postdoctoral training for the biomedical scientist workforce, an area in which adequate data are unavailable. The AAMC will help develop a database that adequately characterizes current trainees and training activities in the biomedical sciences, and will consider establishing a longitudinal tracking system for biomedical science trainees. The Association also will work to develop effective counseling programs for prospective and matriculated doctoral students in the biomedical sciences, and continue its efforts to attract underrepresented minorities into the field.

Governance and Organization

No major restructuring of the Association is planned at present, but some adaptations are proposed to increase the AAMC's effectiveness and to expand the involvement of key leaders within academic medicine.

- The duration and possibly the frequency of governance meetings will be changed to ensure more "cross-talk" among the Association's governing elements and to enable the Association's Executive Council to play a larger role in crafting unified views.
- The Committee on the Strategic Positioning of Faculty Leadership in the AAMC has been formed to explore ways to increase the effectiveness of the Association's Council of Academic Societies in representing faculty leaders in AAMC programming, deliberations, and policy formulation.
- To enable the Association's Council of Teaching Hospitals to represent effectively the new types of institutional organizations that are evolving in the world of teaching hospitals—such as integrated delivery systems, multi-hospital organizations, and joint ventures between hospitals and practice plans—the Association will modify its bylaws to extend membership to appropriate hospital systems.
- To build on the proven effectiveness of the Association's network of groups and sections, which represent and offer professional development for key constituencies within member institutions, the AAMC will establish formal mechanisms for periodic review of each group. Full group status is recommended for the Group on Clinical and Resident Affairs (formerly the Section on Resident Education) and is anticipated for the newly formed gathering of medical school leaders responsible for graduate research, education, and training (the GREAT group).

Implementation of the Strategic Plan

Work to strengthen targeted, ongoing activities already is underway, and new initiatives called for by the plan are now being phased in. Each should be well in evidence within two years. All of the plan's goals are expected to be achieved through prudent allocation of projected AAMC resources, and with external grant and contract support.

The AAMC's strategic plan is intended to help academic medicine harness the momentum of its past success, keep faith with its core values, and take charge of the future.

Context of the Strategic Plan

Academic medicine's achievements in the last half of this century are among our country's proudest. The ingenuity and attainments of our nation's medical schools and teaching hospitals over the short span of a few decades have placed the United States at the forefront in fulfilling every one of academic medicine's special missions: medical education, medical research, and health care, carried out in the context of service to the community. This enviable position has been realized because our society has provided generous support for the education and training of physicians and medical scientists and has made substantial investments in the conduct of university-based medical research. The manifest returns on those investments are the world's most skilled medical practitioners and investigators and the world's wellspring of new therapies and technologies to manage disease and disability.

The ingenuity and attainments of our nation's medical schools and teaching hospitals ... have placed the United States at the forefront in ... medical education, medical research, and health care.

The Achievements of Academic Medicine

Medical Education

Medical schools and teaching hospitals have a fundamental responsibility to educate and train our country's physician workforce. Propelled by a societal concern in the 1960s about an impending physician shortage, new medical schools were created, increasing the total number from 89 accredited allopathic schools in 1965 to the present figure of 125. As new schools were launched and class sizes were expanded at existing schools, the country's total medical school enrollment doubled, rising from fewer than 32,500 to more than 67,000 today. Despite this growth, the qualifications among students applying to medical school have remained exceptionally high. Moreover, the actual number of applicants has reached record levels, as have the numbers of women and underrepresented minorities among them.

Not only have many more new physicians been educated since the mid-1960s, they have until quite recently responded in increasing proportions to the strong societal incentives and exciting opportunities available to pursue residency training in specialized fields of medicine. That the quality and sophistication of American medicine is now the envy of the world is the direct result of their career choices and of the excellent education and training they received. Over the same period of time, the in-pouring of graduates of foreign medical schools into accredited residency programs added to the increase in the population of residents and fellows, already swelled by the trend toward specialization and the lengthening of training. By 1994, more than 103,500 physicians were enrolled in formal graduate medical education (GME) programs; more than 23,500 of these residents were in first-year, entry-level positions, exceeding by over 40% the number of graduating U.S. medical students in that year.

Biomedical Research

The steadily growing federal investment in biomedical research in the latter half of this century enabled medical school faculties to participate decisively with life scientists elsewhere in one of the greatest periods of discovery the world has ever known. From 1965 to 1993, annual federal spending for medical research and development grew tenfold, from less than $1.2 billion to more than $12 billion. In the aggregate, support from all public and private sources for research and development in the health care sector grew from $1.9 billion to $31 billion, with the contribution from industry growing from less than 40% to more than 50% of the total.

The payoff in new scientific knowledge and its translation into the relief of human suffering is arguably one of the United States' most enduring contributions to civilization. And our country and indeed the world will reap still further benefits from our new knowledge thanks to the continued—though probably no longer growing—federal investments that are being made in the training of medical scientists for the future.

Clinical Care

Integral to their core missions of education and research, medical schools and teaching hospitals must provide the fullest possible range of clinical services. Care for the sickest, most unusual, and most vulnerable patients has been among their most highly visible and defining characteristics. Catalyzed principally by the federal Medicare and Medicaid programs, both established in 1965, the changes that have occurred in the realm of patient care services over the past few decades have been no less fundamental than those occurring in the realms of research and education. Indeed, the very financial underpinnings of medical schools have been transformed, now that Medicare and Medicaid pay for patient care services that once were rendered gratis or not at all. Revenues from practice plans in support of medical school activities rose from $25 million in 1965 to over $9 billion in 1994. Revenues in support of medical school programs in hospitals and clinics rose from $31 million to over $3.6 billion over the same period. Importantly, the monies generated by the services of clinically active faculty have served not only to support the growth of the clinical faculty itself, but have contributed critically to the institutional resources needed to sustain the educational and research programs (basic and clinical) of medical schools and teaching hospitals.

Care for the sickest, most unusual, and most vulnerable patients has been among [academic medicine's]...most highly visible and defining characteristics.

Financial Support

It is largely as a consequence of the growth in federal investments in biomedical research and of the greatly expanded reimbursements for clinical services that medical schools and teaching hospitals have been able to achieve such success in fulfilling their crucial societal obligations. The annual revenues from all governmental and private sources that medical schools received in support of their education, research, and clinical activities rose, on average, from $9 million in 1965 to $218 million in 1994. Similarly, teaching hospitals had extraordinary opportunities to expand their valued services to broader segments of the community. For example, sparked by the medical applications of new scientific knowledge and by the favorable payment environment, net patient revenue for all AAMC Council of Teaching Hospitals (COTH) members, adjusted for inflation, more than doubled in the relatively short span between 1980 and 1993, increasing from $19 billion to $40 billion. At the same time, however, teaching hospitals were called upon to provide more and more uncompensated care; for COTH hospitals, charity deductions increased more than four-fold, rising from $600 million to $2.8 billion in 1980 constant dollars.

Faculty Expansion

The many achievements credited to medical schools and teaching hospitals over the past 30 years would not have been possible, of course, without a substantial increase in the number of their faculty. In response to the expanded workload, the number of full-time basic science faculty in medical schools grew more than threefold over this period, and the number of full-time clinical science faculty by a factor of nearly ten.

Economic Importance

But there is even more to the story of academic medicine's achievements than the benefits flowing directly from its basic purposes. In addition to fulfilling their core missions of educating the future workforce of health professionals and medical scientists, improving the quality of available health care through research and advanced technology, and providing essential, often unique health care services to their communities, medical schools and teaching hospitals are now among the most important economic forces in their regions. By employing a large workforce, and by using local vendors to supply most of their required goods and services, medical schools and teaching hospitals add vital energy to all aspects of their communities.

In addition, the success of the biomedical research enterprise, in which academic medicine has played such a decisive role, has spawned some of our country's most competitive industries. U.S. pharmaceutical companies, medical device manufacturers, and biotechnology firms lead the world in translating the key insights gleaned from basic and clinical research into practical tools for improving the public's health. And the continued flow of new findings from academic medicine is crucial for the continued health of these important industries.

Challenges to Academic Medicine of a Changing Environment

During the period of phenomenal growth for academic medicine, many warned that continued expansion at such rates was not realistic and could not be sustained. They were right. It is now apparent that the 1990s are ushering in a new era of constrained resources and heightened accountability for our nation's health care system. It is equally apparent that academic medicine—and each of its missions of education, research, and patient care—are facing profound changes in the process. The tide on which academic medicine and the entire American health care system has until very recently been riding is being stemmed by several key barriers. Among the most relevant to academic medicine are

- pressure to contain the costs of health care
- consolidation of both the payers and the providers of health care
- empowerment of non-physician health care providers
- shifts from a specialist-oriented to a generalist-oriented health care system
- retrenchment of public investments in clinical training and medical research

These five processes are reshaping health care in countless ways. And, equally important, they are being unleashed at a time when our country is allowing exceptional latitude for the marketplace to determine the priorities and characteristics of the reshaped system. Markets are credited with doing many things well, but rewarding the production of "social goods"—goods that lack immediate commercial utility—is not one of them. Academic medicine, for its part, produces just such social goods — educating the future health professions workforce, discovering the new knowledge necessary for continued improvement in the quality of health care, and ensuring access to care for many patients in particular need.

In sum, academic medicine's central challenge is the preservation of its societal missions in the midst of a complex and unduly market-driven transformation of the health care system.

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The following sections present a more detailed discussion of the five key processes that are transforming health care and the fundamental challenges they present to academic medicine.

Pressure to Contain Health Care Costs

Most analysts concede that containing further escalation in health care costs was the principal concern of recent federal efforts to reform the health care system and remains the key objective of the current market-driven reform. Confidence that managed care will provide the mechanisms whereby the system can achieve this objective is widespread. Indeed, managed care plans are growing in market share at extraordinary rates in most parts of the country. Managed care plans achieve cost containment in substantial measure by rigorously limiting the amount of care delivered in hospitals (the principal setting in which both medical students and residents have received their clinical training) and by aggressively seeking and obtaining large price discounts for both inpatient and ambulatory care services. The result is a health care marketplace that is increasingly price-sensitive.

Medical schools and teaching hospitals are particularly vulnerable to the repercussions of such a price-sensitive, managed-care dominated market for medical services. A principal difficulty is the high-cost structure of most teaching hospitals and faculty practices, which places them at a distinct disadvantage when competing on price for managed care contracts against non-teaching hospitals and physicians who lack the added financial costs associated with their academic missions. In addition, as medical schools and teaching hospitals attempt to remain competitive, clinical faculty find it increasingly difficult to meet the "productivity" demands of the marketplace and still have adequate time for teaching and research. Having to compete on price also threatens to jeopardize the quality of the care for which clinical faculty are responsible.

Compounding the difficulties for medical schools and teaching hospitals, managed care plans prefer to contract with provider systems built on a base of generalist physicians who deliver primary care services; by the same token, they frequently shun the practices of academic physicians, where specialist physicians typically predominate. Moreover, academic physicians have depended to a great extent on referrals from community-based practitioners, many of whom are now themselves caught up in managed care arrangements and are thereby inhibited from

referring their patients to non-plan physicians and hospitals. This development has served to shift patients and revenues still further away from medical schools and teaching hospitals.

As a consequence of these new dynamics that are rapidly overtaking the health care marketplace, medical schools and teaching hospitals are being seriously threatened both with an urgent need to reduce their costs and with a sudden shift of both patients and revenues to other, non-academic providers. It is axiomatic to state that medical education and clinical research cannot be conducted without patients and without money. Access to large numbers of patients with a wide variety of conditions is indispensable for educating physicians and for exploring important clinical problems.

Equally important, the costs incurred by the academic missions of education and research are real and must come out of someone's budget. At present, these costs are borne by a complex set of interacting revenue sources, including tuition payments, state and municipal appropriations, grants and contracts from the National Institutes of Health and other sponsors of medical research, special education-related payments from the Medicare program and from some Medicaid programs, expenditures for education and research by the Department of Veterans Affairs and the Department of Defense, and donations from private benefactors. An especially important additional source is the revenue generated by the patient care services provided by teaching hospitals and faculty practice plans, which are precisely the revenues being threatened directly by the price-sensitive, private-sector health care market. Making matters still more challenging, the public-sector support for health care, particularly by the Medicare and Medicaid programs, also is threatened with major cutbacks, which would have profound impacts on medical education and research.

The challenge for the leaders of academic medicine is to ensure that the public is fully informed...about the damage that would be done to the future quality of health care if medical education and research became divorced from the health care delivery system.

The mounting pressures to contain costs in medical schools and teaching hospitals and to prevent the erosion of existing revenues are stimulating many creative solutions. Medical schools, for example, are beginning to roll back faculty salaries, to eliminate costly elective experiences for students, and to consolidate teaching, research, and clinical programs with those of other schools where possible. Teaching hospitals are shortening the length of hospital stays; reducing their staffs; increasing productivity through the use of clinical pathways, care mapping, and guidelines; and replacing costly inpatient procedures with suitable ambulatory care alternatives. But keeping up with the magnitude and pace of the demands remains a major challenge for leaders of academic medicine everywhere.

Consolidation of Both Payers and Providers

A dominant feature of the ongoing transformation of the private health care market is a rapid coalescing of both the payers, on the one hand, and the providers, on the other, into large regional and, in some cases, national conglomerates. Purchasers of health care on behalf of patients (e.g., insurance companies, managed care plans, large employers) are finding that they can get better price and service concessions by merging, acquiring, or otherwise consolidating into larger and larger entities. In response, health care providers are forming vertically integrated delivery systems, multi-hospital chains, large networks of primary care providers, and the like. This intensely entrepreneurial activity has drawn the attention and aggressive participation of new players on the health care scene, including many investor-owned entities.

Medical schools and teaching hospitals often have difficulty doing business in a consolidating market or participating as partners in the consolidating arrangements occurring in their regions. The governance structures of many medical schools and teaching hospitals hamper the timely and coordinated process required for making appropriate business decisions. Their high-cost structures and large numbers of specialists and subspecialists make them unattractive to potential partners. Limited access to capital, especially for publicly funded institutions, is an additional liability that often impedes the crafting of an attractive set of arrangements with other providers. Even other obstacles may arise when the potential consolidation involves one or more investor-owned entities. Fundamental conflicts involving mission, philosophy, and priorities frequently surface and can thwart collaboration.

Despite these formidable obstacles, teaching hospitals and medical schools are moving ahead forcefully to identify suitable partners with which to join forces and are doing so in a wide variety of creative ways. But the possibility remains that many regional health care markets may consolidate without the full participation of their

regions' medical schools and teaching hospitals. Such an outcome would, at the very least, compromise the academic missions of the affected institutions and could even threaten the very survival of some. The challenge for the leaders of academic medicine is to ensure that the public is fully informed about this threat and about the damage that would be done to the future quality of health care if medical education and research became divorced from the health care delivery system.

Empowerment of Non-physician Health Care Providers

Not only has the variety of non-physician health care providers grown substantially in recent years, so too has the range of patient care services that non-physicians can deliver safely, with or without physician supervision. The availability of simplified yet powerful new technologies, coupled with the pressure to contain health care costs, has naturally led managed care organizations and others to reduce their reliance on physicians when lower-cost, competent providers are available to perform the tasks at hand. The public is clearly well served by this development as long as the quality and availability of needed services are not jeopardized.

Medical educators across the country are...modifying their curricula, [and]... trying to establish educational partnerships with managed care organizations.

Nevertheless, the implications for academic medicine of an appropriate broadening of responsibility for certain patient care services, once the exclusive province of physicians, are potentially profound. The critical questions raised for academic medicine are not new, but have taken on much greater urgency because of the rapidity of the changes that are now occurring in the health care environment. Among these questions are:

- How many and what kinds of physicians will be needed in a future populated with new cadres of health care providers?
- How can physicians, with their lengthy education and training, document the added value they bring to quality patient care?
- What new skills will physicians require to equip them to supervise and/or collaborate with teams of other professionals?
- How will the distribution of patient care services among physicians and non-physicians be determined?

Answers to these and related questions are being sought by many academic institutions. Especially promising are the collaborative, multidisciplinary educational programs being designed and implemented at both the student and postgraduate levels. Learning together promises to be the surest way for health professionals to find out how best to work together.

Shifts from a Specialist-centered to a Generalist-centered Health Care System

Managed care organizations have developed coordinated systems of care centered around primary care services delivered predominantly by generalist physicians. Many believe that these systems of care are superior to specialist-centered care, especially because of their putative ability to reduce health care expenditures, but also because of their potential for improving coordination of care among a variety of providers, reducing the redundancy of services, and implementing proven strategies for prevention. Belief also is still widespread, despite evidence to the contrary, that a generalist-centered system will, ipso facto, lessen the shortage of doctors in underserved rural and inner-city locales. Thus, an extensive shift toward generalist-centered care is widely predicted, implying a major reorientation of the content, processes, and products of medical education.

Medical educators across the country are preparing for this shift by modifying their curricula, identifying more generalist faculty to serve as role models, securing more ambulatory care experiences for students and residents, trying to establish educational partnerships with managed care organizations, and strengthening career counseling activities. These efforts, coupled with the strong signals now coming from the marketplace, are credited with a sizable increase in the interest now being expressed by graduating seniors from U.S. medical schools in pursuing a generalist career. In 1992 fewer than 15% of the graduates indicated such an interest, whereas in 1995 more than 27% did.

Leaders of academic clinical practices also are preparing for this shift. Several creative strategies are being pursued to recruit generalist physicians for active participation in the systems of care being formed by many medical schools and teaching hospitals.

Retrenchment of Public Investments in Clinical Training and Medical Research

The prospects for continued growth in direct federal and state support for the education and research missions of academic medicine are distressingly small. Indeed, most observers believe that maintaining even current levels of support will require advocacy efforts of unprecedented proportions. The reasons for such pessimistic predictions are well known: the drive to balance the federal budget, coupled with the public's aversion to tax increases, has replaced a decades-long predilection to expand public investments with a profoundly abstemious climate of retrenchment. As noted earlier, the virtual certainty of diminished public support for academic medicine is compounding the challenges created by the simultaneous erosion of support derived indirectly from patient care revenues.

But the need for public investment in medical education and research has not diminished. In fact, the demands being placed on academic medicine are more resource-intensive than ever before. For example, medical educators must find ways to shift more of the clinical training for both medical students and residents to the ambulatory care setting because hospitals can no longer provide the comprehensive learning experiences that are required. But available evidence shows that ambulatory care settings are considerably more expensive than hospital settings as venues for education. There are a number of reasons for the extra costs of teaching in the ambulatory care setting. For example, a single faculty member can supervise fewer students and/or residents; residents are less available to contribute to student education; and the time needed for teaching has more impact on faculty productivity in the care of patients.

On the research front, medical scientists continue to be challenged to expand academic medicine's investigative agenda to address important questions about health promotion, disease prevention, and clinical effectiveness. The dilemma faced by leaders of the medical research community is how to meet this challenge without new resources when the cost of doing all manner of research is at an all-time high, when a large number of well-trained scientists already are unable to acquire necessary funding, and when the promise of dramatic advances from current lines of medical research is breathtaking.

Shifting Paradigms and New Opportunities for Academic Medicine

The wide-ranging challenges just described have engendered a number of decisive paradigm shifts affecting virtually all aspects of academic medicine. By reorienting its activities in accordance with these shifts, academic medicine can seize the initiative and emerge from its current uncertainties as an even more effective instrument for achieving its primary purpose: improving the health of the public. Many of the requisite shifts already are well underway; others represent sizable tests of academic medicine's mettle.

Medical education is shifting:

From: A principal focus on physicians' learning during medical school and residency

To: A broader focus incorporating responsibility for the life-long learning that physicians will need to maintain relevant knowledge and skills in a rapidly changing profession

From: Heavy reliance on lectures, labs, and didactic experiences in the pre-clinical curriculum

To: More reliance on active, student-directed learning, on problem-based learning, and on the power and efficiency of new information technologies

From: Preparation of physicians for a system characterized by small groups of independent providers operating in a "cost-plus" environment

To: Preparation of physicians destined to function in large, organized systems of care operating in a "cost-contained" managed care environment

From: Preparing students, by reinforcing their ethical grounding, to resist the temptations faced by physicians to do more than necessary for their patient's welfare, given the financial rewards of the traditional fee-for-service system

To: Accentuating, as well, the extreme dangers inherent in the new capitated systems of health care financing, in which physicians must resist the temptation to do less than necessary to care properly for their patients

By reorienting its activities... academic medicine can seize the initiative and emerge from its current uncertainties as an even more effective instrument.

From: Hospital-centered clinical training skewed toward serious and uncommon illnesses

To: Broad-based and well-balanced clinical training utilizing a variety of ambulatory care and community sites as well as hospitals

From: Preparing physicians for the demographics of the American population in the late 20th century

To: Equipping physicians with the knowledge and interpersonal skills to deal effectively with a rapidly aging population that also is becoming increasingly multicultural and economically segmented

From: Assessments of students' performance that depend heavily on measuring their recall of factual knowledge

To: Defining explicit educational goals and measuring students' attainments by evaluating the appropriate application of knowledge in the clinical setting, the actual performance of the requisite clinical and procedural skills, and the satisfactory demonstration of expected professional behaviors

From: A student body and faculty still unrepresentative of the racial/ethnic and gender diversity of American society

To: An academic community of students and faculty reflecting gender equality and the increasingly multiracial and multicultural character of our population

Medical research is shifting:

From: A view that the pursuit of science for science's sake should be sufficient to justify the continued, large-scale investment of public funds

To: An acceptance of responsibility for rapid translation of fundamental research findings into clinical application and for directing a reasonable portion of public investment toward urgent societal problems

From: Limited opportunities for basic scientists and clinical scientists to collaborate

To: Multidisciplinary approaches to addressing outstanding research problems

We must be prepared to change whatever is out of alignment with contemporary realities, all the while upholding the values and beliefs responsible for our past successes and essential for our future vitality.

From: A heavy emphasis on the traditional scientific disciplines

To: A more balanced research agenda that values and rewards excellent clinical, behavioral, health services, and outcomes research on a par with excellent fundamental research

From: A sharp separation of university-based research from entanglements with commercial enterprises

To: An aggressive pursuit of joint ventures, technology transfer, and product development to speed legitimate commercialization of new discoveries

From: A largely self-policing, self-regulating activity

To: Increased external scrutiny and governmental monitoring to assure the public that the scientific process is being carried out with integrity and that their investment in science is well spent

Health care delivery is shifting:

From: Its historic orientation toward the individual patient

To: Concern about the health status of defined populations as well as the well being of individuals

From: Quality measures based largely on the processes of care

To: A sharper focus on the measurable outcomes of care

From: A preoccupation with episodes of illness

To: A balanced emphasis across the spectrum from health maintenance to disease prevention to diagnosis and treatment

From: Hospital-centered systems of care

To: Broad-based, integrated systems utilizing accessible and affordable ambulatory care and community sites as well as hospitals

From: Patient management strategies that seek every available benefit, however marginal or costly

To: Strategies that value effectiveness and parsimony in the use of clinical resources and that weigh evidence over convention in making clinical decisions

From: Physician-centered and specialist-oriented patterns of care

To: Integrated teams of health professionals centered on primary care

From: Incentives that reward achievement of self-determined, individual goals

To: Rewarding individuals for the achievement of organizational goals

Academic medicine as a whole is shifting:

From: Believing that its contributions to public welfare are self-evident and intrinsically valuable

To: Espousing the need for public accountability by demonstrating the value it provides in return for the support it receives.

Implications for Academic Medicine

Surmounting the numerous and prodigious challenges facing academic medicine will require substantial changes in the programs, activities, and structures of medical schools and teaching hospitals over the years ahead. What must not change is dedication to the fundamental missions of education, discovery, and health care. So too must academic medicine remain dedicated to the underlying values and beliefs that have elevated its missions to the high level of public support they have enjoyed. To maintain that support, academic medicine must uphold its belief in

- placing patients' interests uppermost
- scientific inquiry and scholarship as the routes to new knowledge
- public service and accountability
- continued learning
- the humanistic qualities of the medical profession
- open opportunity for men and women from all backgrounds to enter the medical profession
- open access to health care by all
- maintaining high standards in the pursuit of excellence

In consideration of academic medicine's past achievements, its changing environment, and its current challenges, the task now before its leadership is to take charge of the future. To do so, we must re-examine thoroughly all of the means we employ to achieve our tripartite mission. And we must be prepared to change whatever is out of alignment with contemporary realities, all the while upholding the values and beliefs responsible for our past successes and essential for our future vitality.

The AAMC's Strategic Plan, detailed in the following pages, is designed to assist academic medicine in achieving these goals.

Surmounting the numerous and prodigious challenges facing academic medicine will require substantial changes in the programs, activities, and structures of medical schools and teaching hospitals over the years ahead. What must not change is dedication to the fundamental missions of education, discovery, and health care.

The AAMC Strategic Plan

As the preceding background section makes clear, health care in the United States is undergoing a transformation of unprecedented dimensions. Driven by the escalation of health care costs, and greatly accelerated by dominating market forces, this transformation is posing momentous challenges to the unique missions of academic medicine: education, discovery, and health care, fulfilled within the context of service to local, regional, and national communities.

Throughout much of this century, U.S. medical schools and teaching hospitals have pursued these missions and led our country in constructing the foundations for the highest-quality health care the world has ever known. Through medical education, biomedical research, technology development, and care for the sickest, most unusual, and most vulnerable populations, medical schools and teaching hospitals have proven their value for ensuring continuous improvement in the health status of our nation's people.

Now faced with singular challenges to its purposes, scope, and support, academic medicine must take charge of its own future to safeguard its missions while restructuring its means of fulfilling them. The Association of American Medical Colleges (AAMC), the national presence of academic medicine, embraces its ongoing role in supporting institutional decision makers as they steward the enterprise of academic medicine into the 21st century. The AAMC will provide the forum for academic medicine to re-examine its traditions, to identify and affirm its core values, and to align itself with the future.

Faced with singular challenges to its purposes, scope, and support, academic medicine must take charge of its own future to safeguard its missions while restructuring its means of fulfilling them.

The AAMC has developed a strategic plan as a pathway toward fulfilling its role. This plan, presented in the following pages, articulates the AAMC's mission and goals, its fundamental strategic commitments, and its new and renewed actions to help realize academic medicine's aspirations for the future.

Mission and Goals

The mission of the Association of American Medical Colleges is to improve the health of the public by enhancing the effectiveness of academic medicine. The AAMC pursues its mission by assisting academic medicine's institutions, organizations, and individuals in carrying out their responsibilities for

- educating the physician and medical scientist workforce
- discovering new medical knowledge
- developing innovative technologies for prevention, diagnosis, and treatment of disease
- providing health care services in academic settings

The goals of the Association of American Medical Colleges are to

- promote high standards for medical education, medical research, and health care
- uphold academic medicine's missions of education, research, and service in alignment with public need
- inform public policymakers and opinion leaders about the nature and value of academic medicine
- secure appropriate resources for academic medicine to fulfill its education, research, and clinical missions
- maintain collaborative relationships with other organizations serving complementary purposes
- enhance the professional skills of the faculty and staff of academic medicine's institutions

- be fully informed about issues affecting academic medicine
- set the national agenda for the academic medicine community

Strategic Commitments

As part of its strategic plan, the AAMC has made five strategic commitments to guide its actions toward meeting its goals. Each builds upon the AAMC's past commitments and is critical for assisting the leaders of academic medicine in upholding their institutional missions while adapting to the changes that are restructuring American medicine.

The AAMC will be the champion of medical education integrated with research and patient care.

In fulfilling this commitment, the Association will

- stimulate changes in medical education to create a better alignment of educational content and goals with evolving societal needs, practice patterns, and scientific developments
- foster the environment of integrated education, research, and patient care necessary for high-quality medical education
- strengthen the standards of undergraduate, graduate, and continuing medical education

The AAMC will be an advocate for academic medicine's missions of education, research, and patient care.

In fulfilling this commitment, the Association will

- be the voice of academic medicine to express its views, policies, and core values to lawmakers, opinion leaders, and the public
- lead the advocacy effort for academic medicine at the national level

Each [strategic commitment]... is critical for assisting the leaders of academic medicine in upholding their institutional missions while adapting to the changes that are restructuring American medicine.

The AAMC will be the integrating force for academic medicine.

In fulfilling this commitment, the Association will

- promote cohesion, collaboration, and coordinated action by all parts of the Association's constituency to strengthen academic medicine on the national scene

The AAMC will be an agent for change within academic medicine.

In fulfilling this commitment, the Association will

- anticipate changes affecting academic medicine and provide timely alerts to members
- develop new programs to meet members' changing needs
- assist member institutions in making the changes they deem necessary to meet the needs and expectations of their communities

The AAMC will be a provider of services and information to the leaders and institutions of academic medicine.

In fulfilling this commitment, the Association will

- improve its capacity to collect, analyze, and disseminate information relevant to all aspects of academic medicine's missions
- offer services to meet the institutional goals and operational needs of academic medicine's institutions
- support the leaders of academic medicine in meeting their professional responsibilities

New and Renewed Actions

AAMC members have identified three high-priority concerns that require the Association's immediate attention. These are

- the need for reliable information to help institutional leaders cope with the major forces buffeting academic medicine

- the need for strengthened advocacy efforts to cultivate better understanding of and support for academic medicine's missions
- the need for leadership in dealing with questions about the size, composition, and training of the future physician and medical scientist workforce

Fortunately, the AAMC is well positioned to respond appropriately to each of these concerns. Many of the Association's current programs and activities are precisely targeted to address these concerns and can be intensified by the judicious use of existing resources. In addition, available reserves coupled with anticipated external funding will allow the Association to launch several new initiatives to heighten its effectiveness in addressing these and other key issues.

Information

The message from the leaders of academic medicine is clear. "We need to know what's happening to us; we need to know what works and what doesn't; and we need to know it now!"

Providing information has long been a mainstay of the Association's services to its constituents and will continue to be a primary focus of its activities. The ongoing efforts listed below will be enhanced to meet today's heightened needs.

- Educational seminars. The AAMC is planning an expanded roster of educational seminars to deal with contemporary issues affecting academic medicine, with special emphasis on the "seam" issues that (1) tend to separate various AAMC constituent groups and (2) exist on the borders between academic medicine and key stakeholder groups from other sectors of society.
- Electronic communications. The Association is implementing innovative information technologies to provide secure, on-line, immediate access to useful information at any time from any place. Two new information services are being piloted: (1) the Electronic Residency Application Service (ERAS), which links medical students, deans' offices, and residency programs in an Internet-based system of information transfer that will greatly ease the logistical burdens of the current residency application process, and (2) AAMC ACCESS, a listserver system that will provide a forum for the membership to exchange information on timely topics of importance.

Yet another new information service, AMCAS-E, is being readied for piloting and is designed to allow medical school aspirants to complete the demanding application process electronically.

The AAMC also is inaugurating its Internet Web page and intends to exploit fully the capability of this new, flexible, and expandable mode of collecting and distributing information.

- Faculty. The AAMC is mounting efforts to help member institutions (1) monitor the productivity of faculty in their various roles, and (2) calibrate the size and composition of faculties that are needed to reach institutional objectives. The goals of these efforts include the development of tools for financial and faculty resource management and the dissemination of information about selected "best practices."
- Curriculum analysis. Several Association-led activities already are underway to provide the leaders of academic medicine with the information needed to address one of their most daunting challenges: how to realign the content and processes of medical education to meet changing expectations for physicians. These activities include the establishment of a computerized curriculum database and an expansion of the AAMC's Generalist Physician Initiative to embrace identification of relevant curricular content and generalist competencies. In addition, information is being assembled to identify successful models for the design and financing of clinical education in appropriate ambulatory care settings at both the undergraduate and graduate levels.

The message from the leaders of academic medicine is clear. "We need to know what's happening to us; we need to know what works and what doesn't; and we need to know it now!"

- Medical school objectives. Additional information soon will be available from the recently-launched Medical School Outcomes Project. This project, by expanding and updating the Association's GPEP and ACME-TRI initiatives, seeks a national consensus on the specific objectives of the medical school experience. Clarifying the attitudes, values, skills, knowledge, and behaviors that students must demonstrate in order to be awarded the M.D. degree will provide medical schools with standards they can use to evaluate and improve their curricula and to assess student accomplishment.
- Outside studies. When confronted with exceptionally complex issues requiring rapid analysis, the Association has recognized the value of leveraging the capacity of its internal staff by commissioning special studies and surveys by appropriate outside

groups. Examples include the recently completed studies of Medicare risk contracting and Medicaid support for graduate medical education, and the tracking of state legislation related to academic medicine.

- New center. In addition to these ongoing efforts, the Association is creating a major new study center. The Center for the Assessment and Management of Change in Academic Medicine will (1) analyze the impact of the changing health care environment on the nation's academic programs as well as on the organization and financing of the nation's medical schools and teaching hospitals, and (2) optimize the effectiveness of Association efforts to help institutions initiate and manage the changes necessary to preserve their academic and societal missions.

  The center will study trends in education and research, in the integration of clinical services, and in the organization and governance of medical schools, teaching hospitals and relevant faculty bodies. It will develop information on innovations and models that institutions of academic medicine could consider adopting for themselves as they initiate the changes needed for successful adaptation to resource constraints and other environmental stresses.

  The center's activities will augment and help to integrate ongoing efforts of existing AAMC divisions that are charged with maintaining and analyzing relevant databases, conducting policy analyses, and performing focused studies of importance to academic medicine and society.

  The goals of the center will be achieved through a number of initiatives, including the creation of a "sentinel" network of medical schools and teaching hospitals. The response of this network to key environmental factors will provide an opportunity to analyze and share useful information with the membership at large. Surveys, site visits, forums, and the brokering of linkages among members are some of the approaches that will be used to achieve the center's goals.

  Making information available to members in a timely fashion will be a high priority of the center. Through the use of conventional media, e-mail, the Internet, and teleconferencing, members will be able to access useful information quickly and efficiently.

The involvement of key leaders from all segments of the academic medicine community in AAMC policy formulation is critical to the Association's success in serving as the voice for academic medicine on the national scene.

Advocacy

Among the AAMC's most visible activities have been its national advocacy efforts on behalf of academic medicine. As effective as those activities have been over recent years, virtually everyone recognizes that today academic medicine faces a greater need than ever for understanding and support. Business executives, opinion leaders, policymakers, legislators, and the public at large are key actors on the contemporary stage and hold sway over the future course and direction of our country's priorities. Academic medicine's continued ability to fulfill its societal purposes hinges on its ability to make its case before this increasingly skeptical cast.

In conformity with the AAMC's strategic commitment to be the advocate for policies supporting academic medicine's missions, the Association is greatly intensifying its advocacy efforts with the legislative and executive branches by (1) organizing more constituents' visits to key congressional members, staffers, and federal agencies; (2) hiring experienced consultants to help shape strategies and tactics; and (3) augmenting its in-house government relations staff.

Stronger collaborations between the AAMC and other organizations with complementary interests and policy positions also are being forged. For example, joint statements have been issued with such organizations as the American Medical Association, the Association of Academic Health Centers, the American Council on Education, the Association of American Universities, the National Association of State Universities and Land Grant Colleges, the Catholic Health Association, InterHealth, the National Association of Children's Hospitals and Related Institutions, and the National Association of Public Hospitals.

In addition to bolstering established collaborative relationships with individual organizations and with existing coalitions, the Association will seek new strategic alliances with selected professional organizations and private sector stakeholders. The consequences of the stresses currently besetting academic medicine have important ramifications for a great many sectors of American life. Enlisting the cooperation of other national organizations in articu-

lating the benefits that flow from academic medicine's contributions to the public welfare will amplify significantly the Association's advocacy efforts. Just as important, such alliances will serve to sharpen the Association's (and academic medicine's) understanding of the perceptions and expectations that key sectors of our society have of academic medicine and will thereby help shape our agenda for change.

The involvement of key leaders from all segments of the academic medicine community in AAMC policy formulation is critical to the Association's success in serving as the voice for academic medicine on the national scene. To achieve this end, programs will be targeted to meet special needs of existing and emerging leadership groups, and the use of AAMC advisory panels will be expanded as a way to garner expert guidance for the Association.

Inherent in effective advocacy is an advanced communications capability. The AAMC already has begun to expand its in-house staff of communications professionals, who will develop appropriate messages about academic medicine for a national audience. A focused campaign using print and electronic media will be designed around these messages to broaden understanding, both by the AAMC's constituency and by key public stakeholders, of the issues affecting academic medicine.

Leadership on Workforce Issues

Academic medicine's unique mission is to educate and train the future workforce of physicians and medical scientists. Concerns about the size and composition of that workforce have emerged (1) as transformations in the organization and delivery of health care services result in a need for fewer physicians, a shift toward primary care services, and the utilization of less costly, non-physician providers, and (2) as downward trends in public and private investments in biomedical research appear to presage an oversupply of medical scientists.

The AAMC has worked from its inception to assist the leaders of academic medicine in producing an appropriate workforce to meet the country's everchanging needs and expectations. The Association has promulgated numerous policy statements and has developed several programs and services in this arena over the years.

The AAMC ... has concluded that ... the current distribution of residents ... is too heavily skewed toward ... non-generalist disciplines.

Notable examples of ongoing efforts in the workforce arena include

- *Project 3000 by 2000*, designed to achieve parity for underrepresented minorities among medical school matriculants by the beginning of the next century. The project aims to enlarge the pool of qualified minority applicants through enduring partnerships between medical schools and regional institutions responsible for K-12 and college education. Related efforts also are underway to attract and retain more underrepresented minorities in medical school faculties and to increase the number of underrepresented minorities in leadership roles in academic medicine.

- The Women in Medicine program, designed to enhance the success of women medical students and faculty by addressing the special professional needs of women physicians and scientists. Women are significantly underrepresented in leadership positions within academic medicine, and the Association has intensified its efforts to address this deficiency.

- The Generalist Physician Initiative, designed to achieve a proper balance between primary care and more highly specialized physician services. This initiative has helped to identify the obstacles medical students face in choosing and following a generalist career path and is helping medical educators in numerous ways to implement appropriate educational and counseling programs. As a co-initiator of the annual National Primary Care Day, the AAMC also is supporting creative efforts by student groups to bring more attention to the opportunities that exist in the generalist disciplines.

  The Association also is assisting in faculty development activities designed to meet the needs of existing generalist faculty and to facilitate the recruitment and retention to faculties of both full-time and community-based generalist physicians. Finally, the Association is attempting to tackle the nettlesome problem of the persistent shortage of generalist physicians in inner-city and rural locations, a shortage that continues to frustrate the medical profession and the public alike.

- The Medical College Admission Test (MCAT), designed to assist medical schools in assessing their applicants. The test is devised to evaluate the knowledge and skills that are predictive of success in mastering the medical school curriculum. Ongoing efforts are aimed at improving the MCAT's capacity to identify candidates' communication and problem-solving abilities, since there is increasing awareness of the crucial importance of these abilities for the practicing physician.
- Numerous databases, designed to provide useful information about quantitative and qualitative trends in the education of medical students, residents, and fellows.

In addition to expanding the scope and effectiveness of each of these ongoing activities in the workforce arena, two related initiatives are planned:

- The AAMC will lead efforts to encourage a realignment of the size and composition of the physician workforce with society's needs. The AAMC, as well as a host of other organizations and individuals, has concluded that the number of residents completing graduate training and entering practice in this country exceeds future need and, moreover, that the current distribution of residents by specialty and subspecialty type is too heavily skewed toward the more highly-focused, non-generalist disciplines.

  To address this imbalance, the Association will (1) convene a national physician workforce study group to strengthen the analytic base for projecting future need for the various medical specialties, (2) advocate a reduction in the number of international medical graduates who enter training in the United States and eventually practice here, (3) assist GME program directors in identifying suitable alternatives to residents for the delivery of critical patient care services, and (4) strengthen career counseling services for U.S. medical students to ensure that counselors and students have up-to-date information about practice opportunities.
- The Association also will lead efforts to examine the pre- and postdoctoral training for the biomedical scientist workforce. Evidence is mounting that the number of research jobs in traditional laboratory-based settings is, or will soon be, insufficient to accommodate the number of biomedical scientists completing doctoral and postdoctoral training. The Association already has begun to mobilize the leaders of graduate research, education, and training in U.S. medical schools to address the ramifications of this potential imbalance and will continue to convene this group of constituents to press for better understanding of the issues.

  The development of appropriate policy recommendations in this arena is hampered, however, by a paucity of reliable data. The AAMC will assist in developing a database that adequately characterizes current trainees and training activities in the biomedical sciences and will consider the establishment of a longitudinal tracking system for trainees in the biomedical sciences. The Association also will assist in developing effective counseling programs for prospective and matriculated doctoral students in the biomedical sciences. In addition, ongoing efforts to increase the number of individuals from underrepresented minorities in the scientist workforce will continue.

Implementation of the Strategic Plan

Although this strategic plan for the Association is ambitious in scope, successful implementation of all aspects is feasible. The strengthening of targeted ongoing activities is underway already. The new initiatives of the plan are being phased in now, and each should be well in evidence two years hence. Moreover, analysis of the cost of implementing the plan shows no need to increase aggregate, inflation-adjusted revenue from AAMC dues. All of the plan's goals appear to be achievable through prudent allocation of projected AAMC resources coupled with the acquisition of external grant and contract support.

Governance and Organization

The central elements of the current governance and organization of the AAMC have been in place since 1968 and were deemed, after careful review, still to be appropriate as the vehicle for accomplishing the Association's aims. Moreover, given the extensive changes that are occurring throughout academic medicine and the new organizational forms that are evolving, a major restructuring of the Association at this time was thought to be premature at best. Nevertheless, several adaptations of the current governance and organization of the AAMC are proposed in order to increase the effectiveness of the Association and to expand the involvement of key leaders within academic medicine.

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Executive Council

The Executive Council comprises leaders from all of the major components of academic medicine—medical schools, teaching hospitals, faculty, residents, and students. In theory, then, it should be well positioned to perform a crucial integrating role, forging consensus when none would likely emerge without such a presence. In practice, however, the Executive Council frequently is accorded little room to foster consensus because the administrative boards of the individual councils and organizations, having deliberated independently, often reach firm conclusions without having had an opportunity to hear other views. In fact, the administrative boards have a clear responsibility when deliberating independently to adopt views that reflect their particular sector of academic medicine.

This modus operandi is ill suited to the present time, when academic medicine faces such peril and when the Association must speak as much as possible with a single, unified voice. Therefore, to facilitate consensus-building, the duration and possibly the frequency of governance meetings will be changed to ensure more "cross-talk" among the Association's governing elements and to enable the Association's Executive Council to play a larger role in crafting unified views.

Council of Academic Societies (CAS)

During the Association's strategic planning process, participants repeatedly cited the need to enhance the representation of faculty leaders in AAMC programming, deliberations, and policy formulation. Although the Association's Council of Academic Societies is intended to serve this purpose, many expressed the belief that current arrangements could be improved to increase the effectiveness of the CAS in this regard. But no consensus was reached about how to accomplish this goal. Of immediate importance is assuring proper faculty input on such issues as clinical practice in the academic setting, graduate medical education, clinical research, and promotion and tenure. Planning efforts, therefore, will be continued in this arena.

Such terms as "teaching hospital," "academic medical center," and "academic health sciences center" are losing their traditional meanings.

The special ad hoc Committee on the Strategic Positioning of Faculty Leadership in the AAMC has been formed and charged to

- recommend to the AAMC Executive Council specific ways by which faculty leaders within medical schools and teaching hospitals can be engaged more effectively in accomplishing academic medicine's mission and goals
- consider possible changes in the organizational arrangements and programs of the Council of Academic Societies and of the AAMC itself that would promote the involvement of national leaders among (1) chairs of medical school departments, (2) biomedical, behavioral, and clinical scientists, (3) health services and clinical outcomes researchers, (4) innovators in medical education, (5) graduate medical education program directors, (6) authorities in continuing medical education, and (7) directors of academic clinical practice

Council of Teaching Hospitals (COTH)

The transformations that are occurring in the U.S. health care system are affecting no part of academic medicine more than our nation's teaching hospitals. New configurations and relationships are evolving; in the process such terms as "teaching hospital," "academic medical center," and "academic health sciences center" are losing their traditional meanings. Defining precisely what is meant by these terms in many integrated delivery systems, multi-hospital organizations, and joint ventures between hospitals and practice plans is becoming increasingly difficult. Yet the critically important academic roles of clinical education and clinical research, whether played out within a distinct hospital entity or as an integral part of a more comprehensive network of providers, must remain a prominent AAMC concern. Appropriate modifications of Association bylaws will be made to permit the COTH to accommodate this goal.

The COD, OSR, and ORR

The current structure and function of the Council of Deans (COD), Organization of Student Representatives (OSR), and Organization of Resident Representatives (ORR) were examined thoroughly by the strategic planning process and no recommendations for substantive changes are being made.

Advisory Panels

The AAMC has reaped significant benefits from the activities and counsel of the three advisory panels formed in recent years. Those panels are the Advisory Panel on Biomedical Research, the Advisory Panel on Strategic Positioning for Health Care Reform, and the Advisory Panel on the Mission and Organization of Medical Schools. Each not only has fulfilled exceptionally well the assigned task of addressing a specific set of issues for the AAMC, but also has been especially effective in engaging a broad range of AAMC constituencies in formulating policy and developing programs. Consequently, these advisory panels will be continued with strong support, and other advisory panels will be formed as needed to provide the Association's Executive Council and staff with broad input from all of academic medicine's stakeholders.

Groups

The AAMC's groups and sections provide some of the most effective ways to address the needs of those who fulfill the missions of academic medicine. By representing key constituencies within member institutions, all AAMC groups have proved to be excellent vehicles for professional development and networking. Their activities have been more variable in other areas, such as policy development and implementation, program development, project analysis, data collection, and information-gathering about emerging trends. Group steering committees will be encouraged to consider whether their group agendas should be expanded (or combined with others) to encompass these larger roles, and if so, how the resources to do so might be obtained.

Formal mechanisms will be established for periodic Executive Council review of each group to assure its optimal effectiveness. Full group status is being recommended for the Group on Clinical and Resident Affairs (formerly the Section on Resident Education) and is anticipated for the newly formed gathering of medical school leaders in the Group on Graduate Research, Education, and Training (the GREAT group).

The AAMC will remain alert to all opportunities for serving key segments of the academic medicine community through professional development, operational services, and management information that are best addressed at the national level.

Taking Charge of the Future

The AAMC undertook the development of this new strategic plan in recognition of the rapid transformation of our nation's health care system and the resulting profound impact on academic medicine. That our country's medical schools and teaching hospitals have created unexcelled levels of quality in medical education, medical research, and patient care does not lessen the need to understand and respond appropriately to the demands for change. Nor does the need to find new ways for academic medicine to do its job lessen the importance of its missions for the future quality of health care.

The AAMC's strategic plan is intended to help academic medicine harness the momentum of its past success, keep faith with its core values, and take charge of the future.

The AAMC, as the national presence of academic medicine, has adopted this strategic plan to guide its efforts in providing the information, education, and services that constituents need to meet the new challenges they face while upholding their institutions' essential missions. The plan also reaffirms the AAMC's intent to provide effective advocacy for academic medicine at the national level and to strengthen public understanding and support for its missions. Finally, the AAMC's strategic plan is intended to help academic medicine harness the momentum of its past success, keep faith with its core values, and take charge of the future.

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